Previous Traumatic Birth: An Impetus for Requested Cesarean Birth

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Abstract

This paper addresses the meaningfulness of the childbearing experience and how a traumatic occurrence can affect women for years into the future. Every woman deserves to have a fulfilling childbearing experience, even if it may be different from the one she imagined. This paper examines the phenomenon of previous traumatic birth and its potential effects on choices during subsequent pregnancies. Discussion includes how childbirth educators can assist women in healing from past birth traumas and preventing them from recurring.

***Journal of Perinatal Education,* 12(1), 1–5;** *traumatic birth, subsequent births, childbirth education.*

Introduction

Giving birth is an empowering experience for women and their partners when they have the opportunity to make choices that will influence the outcome of this significant life event. For some women, however, the birthing experience brings with it feelings of victimization, betrayal, or loss that can result in both emotional and psychological damage. Because birth is a powerful experience, when it is traumatic, its impact can be enormous. This paper examines the phenomenon of previous traumatic birth, how previous traumatic birth affects

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choices during subsequent pregnancies, and how health professionals, including childbirth educators, can assist women in healing from past birth traumas.

Problem Definition

Traumatic birth has not been well studied and is not well represented in the literature. "Traumatic birth" may be referred to as physical injury, although it can also involve psychological trauma. When birth is perceived to be traumatic, women lose more than just their dream of birth and often judge themselves to be inadequate in some way (Panuthos & Romero, 1984). A woman's perception of traumatic birth has been described as related to the use of pitocin, forceps, vacuum extraction, and cesarean section. It can also be related to fear of maternal or fetal death, unrelieved pain during labor and/or childbirth, long and difficult labor, perceived loss of control during the childbirth experience, and a dead or damaged infant (Panuthos & Romero, 1984).

A demand made by a multiparous mother for an elective cesarean section should be taken seriously because it may suggest a previous traumatic birth. Consequences of a previous traumatic birth may include stress and anxiety that escalate during the last trimester of a subsequent pregnancy (Ballard, Stanley, & Brockington, 1995) or a demand by the pregnant woman for an elective cesarean section (Ryding, 1993). The consequences may also include avoidance of future childbearing. These authors report that some women avoid future pregnancies because they cannot perceive the possibility of healing from the trauma of childbirth or they do not realize that, with careful planning, birth can be different from what they experienced the first time. The literature suggests that many of the women seeking an elective cesarean section are doing so for psychological reasons, particularly a previous traumatic birth experience (Reynolds, 1997; Ryding, 1991, 1993). Therefore, the problem to be examined here is how to counsel a woman who demands an elective, nonmedically indicated cesarean section due to a previous traumatic birth.

In a study conducted by Ryding (1991), a significant number of mothers who initially requested a cesarean section for psychosocial reasons chose a vaginal birth after counseling or short-term psychotherapy. To request an elective cesarean birth implies a high level of anxiety about childbirth. However, elective cesarean section does not "cure" the fear of childbirth. Thus, when a pregnant woman requests an elective cesarean section that is not medically indicated, counseling is indicated (Ryding, 1993).

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Pregnancy can be a time for healing and building strength from previous traumatic birth experiences. Typically, memories of the previous pregnancy, labor, and birth emerge with the current pregnancy. If a woman is allowed to acknowledge these memories with herself and with someone she trusts, her chances of changing her perceptions are good (Madsen, 1994). Thus, women who show evidence of a previous traumatic birth may benefit if they are offered and encouraged to participate in counseling. Such counseling would include exploration and discussion of the earlier traumatic birth experience, feelings concerning disappointment, issues of trust, and the woman's fear of childbirth (Ryding, 1993).

Pregnant women who accept that normal birth is the standard can be encouraged to plan a vaginal delivery, regardless of their previous method of delivery. The exceptions include women who have a history of a classic vertical or unknown uterine cesarean incision and those with medical contraindications to vaginal birth. All women with prior cesarean births and previous traumatic births should be offered education or counseling (as needed) to increase their chances for a positive, empowering, vaginal birth. For example, women with previous cesarean births can be encouraged to seek vaginal birth after cesarean (VBAC) support groups and appropriate childbirth preparation classes. The current vaginal birth rate for VBAC delivery ranges from 60% to 80% (American College of Obstetricians and Gynecologists, 1999).

Counseling for these women should include information about resources that help them gain more control in planning their next birth experience. For example, women and their partners should be encouraged and

assisted in researching the philosophy and practice when selecting their childbirth educator, health care providers, birth setting, doula, and the people who will support them during the pregnancy, labor, delivery, and postpartum periods (Freedman, 1999). Once the options become clear, women and their partners can also be encouraged to make informed choices about their upcoming birth and, possibly, to explore less familiar options and alternatives to common medical interventions that they may have previously experienced as part of their trauma (Freedman, 1999).

Risks of Elective Cesarean

The risk-and-benefit ratio changes when a woman chooses an elective, nonmedically indicated cesarean birth. The risks for the mother are primarily associated with the surgical procedure itself. A cesarean birth is major abdominal surgery associated with increased maternal morbidity and mortality. The increased risk of postpartum complications that follows a cesarean birth include hemorrhage, infection, anesthesia-related problems, injury to other internal organs (such as a nicked bladder or bowel), and psychological stress (Gilbert & Harmon, 1998). The role of the woman in cesarean birth with no trial labor is not necessarily totally passive; thus, the opportunity for a woman to find her strength through giving birth no longer exists for that birth. The long-term effect of this on a society where elective cesarean becomes the norm is totally unstudied.

Vaginal birth is safer for the newborn. A lower incidence of respiratory distress occurs in infants delivered vaginally versus those delivered by cesarean birth. This is because active labor stimulates reabsorption of fetal lung fluid, and the stress of labor helps to prepare the fetus for extrauterine life—neither of these events occur in an elective cesarean birth, which does not include trial labor (Gilbert & Harmon, 1998). The increased safety of a normal vaginal birth for infants is not widely known to parents who may assume the opposite.

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Whether medically indicated or not, care providers should be sensitive to lowering the postpartum risks associated with cesarean birth. When poorly managed, mothers who deliver by cesarean birth may be delayed in holding their babies for hours following birth or report having too much pain to enjoy the baby. If given general anesthesia, women may later report that they grieve over electing not to be consciously present at their baby's birth (Freedman, 1999).

In addition to recognizing the risks of an elective, nonmedically indicated cesarean birth, caregivers must recognize the potential benefits of an elective cesarean section among the birth options for a select group of previously traumatized pregnant women. Although, with support, many women successfully deal with their prior birth trauma and seek out increased control and less intervention, in subsequent childbirth experiences, some women cannot come to terms with their previous trauma, even with therapy. Serious consideration of their request for an elective cesarean birth is reasonable in order to prevent further trauma. The Appendix outlines guidelines for diagnosing and treating women with previous traumatic births.

Introduction of Traumatic Birth in Perinatal Classes

Historically, childbirth classes informed women about the stages of labor and techniques that might be used during labor. Today's increasingly comprehensive model of childbirth education addresses the body, mind, and spirit when the childbirth educator encourages the couple to make informed choices about their upcoming birth. In this model, any emotional issues that arise during pregnancy and birth are addressed, ideally beginning early in the pregnancy or preconceptually. Childbirth educators can design small group work in classes that serve as a source of support for exploring emotional issues such as fear, stress, and loss that may occur during pregnancy and delivery. These emotions may arise from a previous traumatic birth or from stories from family and friends. Virtually no one comes to pregnancy without some impressions about giving birth. Addressing such issues gives legitimacy to their importance to expectant families, and asking open-ended questions that prompt further discussion has the potential to help fami-

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lies prepare for their upcoming birth or heal from past losses (Freedman, 1999).

In the case of a past birth trauma, as with all losses, grieving is essential to healing. Without permission and encouragement to grieve, the burden of pain is likely to remain. Thus, the task of childbirth education related to birth trauma is threefold. One goal is to prevent trauma in the currently expected birth by assisting couples to make choices in care providers and care settings that fit well with their personal birth vision. Then, the couples may be encouraged to communicate that birth vision through discussion of a birth plan. Sharing strategies for coping with labor is preventative work and includes teaching women exercises to reduce the incidence of back labor from a posterior head. It also includes recommending that couples who plan a hospital birth wait until the mother can no longer talk and walk independently through contractions before reporting to that setting. This is in order to lessen the cascade of interventions that more often occur with an early admission. Preventative efforts also include referrals to competent doulas for labor support.

If women experience birth trauma or disappointments, the second task of the childbirth educator is to prepare them to engage in a healing process in the early postpartum. It has been generally recognized that, in remembering and telling their birth stories, women begin the healing process (Freedman, 1999). Thus, all women may benefit when visited immediately following childbirth while still in the hospital or birth center and again following discharge to evaluate their well-being and feelings about the birth experience. This may result in preventing a lasting perception of trauma in cases and faster healing in other situations. If this does not occur, women may be taught to request a review and discussion with their care provider who, in some instances, can put the events in a more understandable context and reduce the perception of trauma. Writing or verbally sharing the events can initiate healing. Childbirth educators who follow the experience of their students should also be alert for a response to traumatic birth that suggests the need for seeking immediate therapy, as opposed to waiting until the next pregnancy.

The third task of the childbirth educator is to be aware of women in class who bring unresolved birth trauma memories with them from a previous birth. Some women will benefit adequately from the class activities and discussions. Others may need to be taken aside and encouraged to tell their story privately because they are intensely focusing on past trauma in a way that is not beneficial to other class members. Finally, some mothers may need to be sent to therapy to begin healing their level of trauma. This judgement call may benefit from a discussion between the childbirth educator and current care provider, with the woman's permission. The woman who firmly decides to have an elective cesarean due to birth trauma is not likely to join a late-pregnancy childbirth class. However, she may be reached in a first-trimester pregnancy class or a prenatal exercise class. The childbirth educator who gains skill in counseling or referring such women may want to make this service known to physicians or midwife prenatal care providers who are frequently in a position to be the first to learn of this situation.

Research Directions and Questions

Given the small, but noteworthy, contributions in this area of study to date, further research is warranted for the following questions:

1. What is the prevalence of previous traumatic birth and what are its short- and long-term consequences for women and their families?
2. Which obstetric practices lead to traumatic birth, as perceived by women? If so, how can these practices be minimized or prevented?
3. How can health care providers best assist women in the childbearing cycle to heal from previous traumatic birth experiences?

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Appendix Traumatic Birth Protocol/Guidelines for Care Providers

Traumatic birth may be defined as a physical or traumatic injury occurring during the labor and/or the birthing period. Because traumatic birth is subjective in nature, it should be defined and recognized as such when a woman perceives the labor and/or birth to have been traumatic.

A. Differential Diagnosis
   1. Fear
   2. Anxiety

B. Risk Factors
   1. Use of interventions such as pitocin, forceps, vacuum extraction, and cesarean section
   2. Unrelieved pain during labor and/or childbirth
   3. Fear of maternal or fetal death
   4. Long and difficult labor
   5. Perceived loss of control during the childbirth experience
   6. A dead or damaged infant

C. Findings/Diagnosis
   1. Avoidance of childbearing
   2. Stress and anxiety, escalating during the last trimester of pregnancy
   3. Demand during pregnancy for an elective cesarean section

D. Management/Treatment – Expectant Parent Education and Follow Up for Those Showing Signs of Previous Traumatic Birth
   1. Encourage the patient to join childbirth preparation classes.
   2. Women who present either requesting an elective cesarean delivery or showing evidence of a previous traumatic birth should be offered and encouraged to participate in psychotherapy, which includes exploration and discussion of the earlier traumatic birth experience, feelings concerning disappointment, issues of trust, and the woman's fear of childbirth.
   3. Encourage and assist the woman in researching and selecting a childbirth educator, health care providers, doulas, and people who will support her during pregnancy, labor, delivery, and the postpartum period.
   4. Encourage the woman to make informed choices about upcoming birth, which include appropriate choices and alternatives to common medical interventions.
   5. Discuss the risks of an elective, nonmedically indicated cesarean section for both mother and infant.
   6. Follow up during the postpartum period to assess the woman's well-being and feelings about the birth experience.

E. Management/Treatment for Women with Previous Trauma Related to Cesarean Birth
   1. Encourage the woman to join a VBAC support group, if appropriate.
   2. Women with prior cesarean deliveries and previous traumatic births should be educated regarding the positive chances for vaginal delivery and encouraged to attempt vaginal birth.